Campground Pediatrics + Wellness Center

UNEMANCIPATED MINOR AUTHORIZATION FOR MEDICAL TREATMENT

(When the parent is not present)

Name of Minor___________________________________ DOB_____________ Health Insurance Plan/Policy#________________________

Allergies/Special Conditions____

Name of Minor____________________________________ DOB_____________ Health Insurance Plan/Policy#________________________

Allergies/Special Conditions____

Name of Minor____________________________________ DOB_____________ Health Insurance Plan/Policy#________________________

Allergies/Special Conditions____

Name of Minor(s)____________________________________ DOB_____________ Health Insurance Plan/Policy#________________________

Allergies/Special Conditions____

If more than 4 minors please check here and fill out information on the back: ☐

I/We, being the parent(s) or legal Guardian(s) of the above named minor(s), do hereby appoint (***All fields must be filled in for form to be valid):

1) Name:____ Phone:______________________

Driver's License Number: __________________________________ ___________

2) Name: ____ Phone:______________________

Driver's License Number: ____

to act on in my/our behalf in authorizing medical, dental, surgical care, and hospitalization (including billing my or my child's insurance policy) for the above named minor(s) during the period(s) of my/our absence, from:

_______________________ through_________________________ OR for always initial here ___________________***

Month/ Date/ Year Month/ Date/ Year

***This authorization/consent will remain in effect until it is revoked in writing by parent/legal guardian or minor turns 18 years old.

This document shall be presented to a physician, dentist or appropriate hospital representative at such time as medical, dental, surgical care or hospitalization may be required.

____	____
Parent/Guardian Signature Date	Parent/Guardian Signature Date
____	____
Parent/Guardian Printed Name	Parent/Guardian Printed Name
Address:____________________________________	Address:____
City:_______________ State:____ Zip:_________	City: ____________________State:_______Zip:_____________
Phone:_________________________	Phone:___________________________
Witness:___________________________	Date:__________

Signature of Appointed Representative of Parent/Guardian : _______________________________ Date:________

Signature of Appointed Representative of Parent/Guardian : _______________________________ Date:________

This is a legal document. Take it with you and give it to the physician, dentist, or hospital representatives so that necessary treatment can be given to a child whose parents/legal guardians are not present.

Revised Feb 2018